"STAYING HEALTHY" ASSESSMENT - Adolescents, 12–17 years of age

Child's name (first, last)	Date of birth ☐☐/☐☐/☐☐	Sex ☐ Male ☐ Female	Today's date ☐☐/☐☐/☐☐
Your name	Relationship to child ☐ Parent ☐ Guardian ☐ Relative ☐ Friend ☐ Other		

For Clinical Use
Assistance needed:
Reading: ☐ Yes ☐ No
Interpreter: ☐ Yes ☐ No

You and your child's health care team can work together towards better health. Please answer these questions as best you can. You may check (✓) "Skip" if you do not know an answer or do not wish to answer. You may talk with your provider about any questions. Your answers will be protected as part of your child's medical record.

Annual Review Date/Initials

					Interventions Code/Date/Initials
Sample Question and Answer: Do you play sports?	✓ Yes	No	Skip		
Do You:					
1. Live at home?	Yes	No	Skip		
2. Go to school?	Yes	No	Skip		
3. Receive health care from anyone besides a medical doctor (such as an acupuncturist, herbalist, curandero, or other healer)?	No	Yes	Skip		
4. See the dentist at least once a year?	Yes	No	Skip		
5. Drink milk or eat yogurt or cheese at least 3 times each day?	Yes	No	Skip		
6. Eat at least 5 servings of fruits or vegetables each day?	Yes	No	Skip		
7. Try to limit the amount of fried or fast foods that you eat?	Yes	No	Skip		
8. Exercise or play an active sport 5 days a week?	Yes	No	Skip		
9. Think you need to lose or gain weight?	No	Yes	Skip		
10. Often feel sad, down, or hopeless?	No	Yes	Skip		
11. Always wear a seat belt when riding in a car?	Yes	No	Skip		
12. Always wear a helmet when riding a bike or skateboard?	Yes	No	Skip		
13. Spend time in a home where a gun is kept?	No	Yes	Skip		
14. Spend time in a home with anyone who smokes?	No	Yes	Skip		
15. Often spend time outdoors without sunscreen or other protection such as a hat or shirt?	No	Yes	Skip		

For Clinical Use
Intervention Codes: C: Counseling EM: Educational Materials R: Referral F: Follow-up Needed SPN: See Progress Notes

Patient Stamp

Patient Number _____ Plan Name/Number _____

If patient stamp not used, write in Patient and Plan Name/Number

Your answers to questions about sex and family planning cannot be shared with anyone, including your parents, without your special written permission.				*For Clinical Use* **Interventions Code/Date/Initials**
	Do you ever:			
16.	Smoke cigarettes or cigars or chew tobacco?	No	Yes	Skip
17.	Drink alcohol such as beer, wine, wine coolers, or liquor?	No	Yes	Skip
18.	Drive a car after drinking or ride in a car driven by someone who has been drinking?	No	Yes	Skip
19.	Use drugs such as marijuana, cocaine, crack, crank, or ecstasy?	No	Yes	Skip
20.	**Have you ever had sex?** *If "yes," continue to next question. If "no," go to question 26.*	No	Yes	Skip
21.	Do you think you or your partner could be pregnant?	No	Yes	Skip
22.	Have you had sex without using birth control in the last year?	No	Yes	Skip
23.	Do you think you or your partner could have a sexually transmitted disease?	No	Yes	Skip
24.	Have you or your partner(s) had sex with any other people in the past year?	No	Yes	Skip
25.	Did you or your partner use a condom the last time you had sex?	Yes	No	Skip
	Have you:			
26.	Ever been forced or pressured to have sex?	No	Yes	Skip
27.	Ever been hit, slapped, kicked, or physically hurt by someone?	No	Yes	Skip
28.	Ever carried a gun, knife, club, or other weapon?	No	Yes	Skip
29.	**Do you have other questions or concerns about your health?** (Please identify) _____ _____ _____	No	Yes	Skip

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Privacy Statement

The Information Practices Act of 1977 (California Civil Code 1798) and the Federal Privacy Act (5 USC 552a, Subdivision (E)(3)) require this notice to be provided when collecting personal information from individuals. The information on this form is requested by your health care provider, health plan, and the Department of Health Services for purposes of providing health education services. Furnishing the information requested on this form is optional for the patient. Failure to provide the information requested will not result in any negative consequence for the patient. Information collected on this form is to be maintained in the patient's medical record, and is subject to the same medical and legal protection as other information maintained in the patient's medical record. State law and regulation including reporting requirements and protection of patient confidentiality applies to all information identified on this form. Within the constraints of these laws and regulations, certain information collected on this form may be transferred to state and local governmental and regulating agencies, contractedhealth plans, and health care providers.